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	17E613	A. BUILDING _____ B. WING _____	08/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: The facility had a census of 38 residents. Based on observation, interview, and record review, the facility failed to promote care in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of his/her individuality during dining (Non-sampled resident #5 and sampled resident #6) and when the facility posted a sign by resident #23's door indicating the resident required special precautions. - During a dining observation on 8/13/12 at 11:56 p.m., direct care staff J fed non-sampled resident #5 his/her lunch. After giving the resident a bite of food, direct care staff J used the spoon to wipe food from the resident's mouth, then fed the excess food to the resident. On 8/15/12 at 11:57 a.m., direct care staff J fed resident #5 in the same manner, scraping excess food from the resident's mouth, then feeding the food to the resident.	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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During an interview on 8/16/12 at 8:37 a.m., direct care staff J stated the resident did not open his/her mouth very far and when feeding the resident excess food would accumulate on the resident's lips. Direct care staff J confirmed he/she used the spoon to wipe the excess food from the resident #5's mouth.

An interview on 8/16/12 at 3:21 p.m. with administrative nurse B revealed staff should use a napkin, not a spoon to wipe excess food from a resident's mouth when feeding them.

The facility's December 1991 " Swing Bed and Long Term Care Resident Rights " packet indicated " the resident has a right to a dignified existence .... The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident ' s dignity and respect in full recognition of his or her individuality " .

The facility failed to promote care in a manner that maintained resident #5's dignity during dining when staff used a spoon rather than a napkin/cloth to remove excess food from the resident's mouth.

- Resident #6's 6/5/12 Quarterly MDS (Minimum Data Set) Assessment reported severely impaired cognition, the need for total assistance of 1 staff for transfers, and limited assistance of 1 staff for eating.

Resident #6's care plan included an entry on 12/21/11 that instructed staff to bring the resident

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out to the dining area in a geri-chair (a large, reclined chair that assisted residents to sit upright) at lunch time for short periods of time and assist the resident to eat.

During observations on 8/13/12 between 11:26 a.m. and 12:30 p.m., staff placed resident #6, while he/she sat in a geri-chair, approximately 3 feet away from a dining room table and faced resident #6 geri-chair away from other residents. Direct Care G sat with his/her back to resident #6, turned toward resident #6 occasionally to hand him/her food to eat independently, and failed to converse with resident #6 during the lunch meal.

During an interview on 8/13/12 at 12:42 p.m., Direct Care Staff N reported that he/she did not like the way that resident #6 sat facing away from other residents in the dining area but the resident's condition restricted staff from transferring him/her to a dining room chair.

During an interview on 8/14/12 at 11:34 a.m., Administrative Nursing Staff B reported that staff provided a bedside table for resident #6 and confirmed that the facility failed to maintain resident #6's dignity when staff sat with their back to resident #6, failed to converse with resident #6, and failed to face resident #6 toward other residents during the lunch meal.

The facility's December 1991 "Swing Bed and Long Term Care Resident Rights" packet indicated "the resident has a right to a dignified existence.... The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her

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individuality".

The facility failed to promote care for resident #6 in a manner and in an environment that maintained/enhanced his/her dignity and respect in full recognition of his/her individuality during dining.

- Resident #23's physician's orders included an admission date of 7/31/12, an 8/8/12 order for Flagyl (an antibiotic) 500 mg (milligrams) orally three times a day for 14 days for C-diff (Clostridium difficile, a bacteria that caused diarrhea), and to "use all needed precautions".

Resident #23's initial care plan failed to include the 8/8/12 instructions to use contact precautions while providing resident #23's care.

During an observation on 8/14/12 at 8:36 a.m., the facility posted a sign that indicated "Contact Precautions" approximately 5 feet off the ground in the hallway next to resident #23's door.

During an observation on 8/14/12 at 2:12 p.m., resident #29 walked near resident #23's door with Direct Care Staff M. Resident #23 pointed at the "Contact Precautions" sign and asked Direct Care Staff M, "What's going on in there? What is wrong with them?"

During an interview on 8/16/12 at 10:31 a.m., Administrative Nursing Staff B reported resident #29 asked repeatedly about the sign and confirmed the facility failed to maintain resident #23's dignity by placing a "Contact Precautions" sign outside of resident #23's door.

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F 241	Continued From page 4 The facility's December 1991 "Swing Bed and Long Term Care Resident Rights" packet indicated "the resident has a right to a dignified existence.... The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality". The facility failed to promote care for resident #23 in an environment that maintained/enhanced his/her dignity and respect in full recognition of his/her individuality, when the facility posted a sign by the resident ' s door indicating the resident required special precautions.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		

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This REQUIREMENT is not met as evidenced by:
The facility had a census of 38 residents with 19 sampled for review.

Based on observation, interview, and record review, the facility failed to develop a comprehensive nursing care plan that included measurable objectives and timetables to meet the residents' medical, nursing, mental and psychosocial needs identified in the comprehensive assessment for 2 of 19 sampled residents related to their individual activity interests. (#26 and #32)

Findings included:

- Resident #26's 4/15/12 annual MDS (minimum data set) assessment revealed the resident had a BIMS (brief interview for mental status) score of 4 which indicated severe cognitive impairment. The assessment indicated resident #26's activity preferences related to music, animals, news, group activities, favorite activities, going outside, and religious services as "somewhat important". The resident performed ADLs (activities of daily living) independently except he/she required assistance with dressing and personal hygiene.

Resident #26's 4/25/12 nursing care plan for alteration in thought processes included the following interventions related to the resident's activity program:
* Keep activities and routine constant as possible.
* Reality orientation

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F 279	Continued From page 6 * Encourage family to write letters to [the resident] so that [he/she] does receive mail. * On occasion [the resident] does go out on facility ride or to an appointment... The nursing care plan lacked interventions related to the resident's individual activity preferences identified in the comprehensive assessment and activity evaluation. A 7/11/12 Activity Evaluation revealed resident #26 had the following current interests: barber, bingo, community outings, exercise, family/friend visits, group discussions, music, religious services, shopping, sing-alongs, and social parties. The evaluation also indicated the resident enjoyed visiting with staff and other residents and his/her son remained involved in the resident's care. During an observation on 8/15/12 at 10:08 a.m., resident #26 napped on his/her bed while other residents participated in a "Trivia" group activity in the dining area. An interview on 8/15/12 at 5:00 p.m. with direct care staff K revealed resident #26 liked to walk outside and enjoyed drinking coffee in the dining room. He/she stated the resident also liked bingo, but did not go [on this day] because he/she wanted to take a nap. During an interview on 8/16/12 at 8:45 a.m., activity staff D revealed he/she did not have an individualized activity plan or program for resident #26. Activity staff D highlighted on the activity calendar what activities the resident attended, but did not have an individual plan or goals related to the resident's activity program. Activity staff D	F 279		

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further added that he/she had no input into the development of the resident's activity care plan.

On 8/16/12 at 11:01 a.m. Licensed nurse C stated he/she reviewed what activities the resident attended and also what he/she observed them attending then developed the activity care plan from that information. Licensed nurse C confirmed activity staff D had no input into the development of the activity care plan and the care plan lacked information related to the resident's individual activity interests and preferences.

The facility failed to develop a comprehensive nursing care plan that included measurable objectives and timetables to meet resident #26's activity needs and interests.

- Resident #32's 12/4/11 annual MDS (minimum data set) assessment revealed the resident had a BIMS (brief interview for mental status) score of 4 which indicated severe cognitive impairment. The MDS indicated resident #32's activity preferences related to animals, favorite activities, spending time away, spending time outdoors,and religious activities as "somewhat important". He/she performed ADLs (activities of daily living) independently except he/she required assistance with dressing.

Resident #32's nursing care plan, revised on 7/25/12, for activity deficit included the following interventions:
* Encourage rest periods as needed.
* Encourage activities of choice.
* Have television on in [his/her] room
* Family does take out of the facility at times to go check cattle or go to family member's house

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or just drive around.
The nursing care plan lacked interventions related to the resident's individual activity preferences identified in the comprehensive assessment and activity evaluation.

A 5/31/12 Activity Evaluation listed the resident #32's current interests as: barber, community outings, family/friend visits, music, radio, religious services, social/parties, sports, television, and walking. The evaluation also indicated the resident had a good sense of humor, liked to tease, and had good family support of spouse, children, and grandchildren.

During an observation on 8/15/12 at 2:00 p.m., resident #32 walked outside in the facility courtyard with activity staff D.

An interview on 8/16/12 at 12:09 p.m. with direct care staff H revealed resident #32 attended some activities, but when they asked him/her to go, the resident would become agitated. Direct care staff H stated the resident liked to sleep.

During an interview on 8/16/12 at 8:45 a.m., activity staff D revealed he/she did not have an individualized activity plan or program for resident #32. Activity staff D highlighted on the activity calendar what activities the resident attended, but did not have an individual plan or goals related to the resident's activity program. Activity staff D further added that he/she had no input into the development of the resident's activity care plan.

On 8/16/12 at 11:01 a.m. Licensed nurse C stated he/she reviewed what activities the resident attended and also what he/she observed

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F 279	Continued From page 9 them attending then developed the activity care plan from that information. Licensed nurse C confirmed activity staff D had no input into the development of the activity care plan and the care plan lacked information related to the resident's individual activity interests and preferences. The facility failed to develop a comprehensive nursing care plan that included measurable objectives and timetables to meet resident #32's activity needs and interests.	F 279		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 38 residents. The facility identified 11 residents as cognitively impaired and independently mobile. Based on observation, interview, and record review, the facility failed to ensure the environment remained free of potential accidents/hazards for 11 cognitively impaired, independently mobile residents when staff stored potentially hazardous chemicals in areas accessible to the residents. Findings included:	F 323		

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F 323	Continued From page 10 - An initial tour of the facility on 8/13/12 at 10:30 a.m. revealed an unlocked whirlpool room on the east hall of the facility. The whirlpool room contained an unlocked cabinet and shelf with the following: * Clorox bleach 98 ounce (full) labeled "Keep Out of Reach of Children" and "Danger: Corrosive" * Breakdown XC Odor Eliminator (1/2 full) labeled "Keep Out of Reach of Children" * Cavi-Wipes Dispenser labeled "Keep Out of Reach of Children" During an interview on 8/13/12 at 5:00 p.m., administrative nurse B confirmed the rooms with the whirlpools should remain locked. On 8/16/12 at 4:00 p.m., administrative nurse B revealed the facility had 11 independently mobile residents with cognitive impairment. The facility's 10/31/06 "Safety Regulations" policy and procedure stated, "Hazardous substances are not left unattended at any time or stored in areas accessible to residents". The facility failed to ensure the resident environment remained free of potential hazards for 11 cognitively impaired, independently mobile residents when staff stored potentially hazardous chemical products in areas accessible to residents.	F 323		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive	F 364		

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F 364	Continued From page 11 value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: The facility reported a census of 38 residents and one kitchen. The facility also reported 2 of the 38 residents received a pureed diet. Based on observation, interview, and record review, the facility failed to provide palatable food at the proper temperature for 2 of the 2 residents who received a pureed diet. (Resident #5 and #25) Findings included: - Observations on 8/15/12 between 10:50 a.m. and 11:25 a.m. revealed Dietary Staff L prepared 2 pork chops, 2 servings of green bean casserole, and 2 servings of chopped potatoes, separately into a pureed consistency as directed by the facility's recipes for residents #5 and #25. Observations on 8/15/12 between 11:25 a.m. and 11:40 a.m. revealed Dietary Staff L failed to monitor the temperatures of the pureed pork chops, pureed green bean casserole, and pureed potatoes prior to serving to resident #5 and #25. Upon request on 8/15/12 at 11:40 a.m., Dietary Staff L checked the temperature of the pureed food and noted the following temperatures: * pork chops, 109.9 degrees F (Fahrenheit) * green bean casserole, 122.4 degrees F * potatoes, 111.0 degrees F	F 364		

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F 364	Continued From page 12 During an interview on 8/15/12 at 11:47 a.m., Dietary Staff L reported he/she never checked the temperature of the pureed food prior to service and confirmed the facility failed to serve the pureed pork chops, green bean casserole, and potatoes at the proper temperatures to resident #5 and #25. Review of the facility's July 2012 and August 2012 food service temperature logs revealed staff failed to monitor the temperature of the pureed food prior to all meal services. The facility failed to provide palatable food at the proper temperature for residents #5 and #25 who received a pureed diet.	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: The facility reported a census of 38 residents, 1 kitchen, and 1 dining area. Based on observation, interview, and record review, the facility failed to prepare, distribute,	F 371		

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and serve food under sanitary conditions for 36 of the 38 residents.

Findings included:

- An observation on 8/13/12 at 11:49 a.m. revealed Direct Care Staff N touched his/her nose then touched resident #23's bread with his/her bare hand. Direct Care Staff N buttered the bread and placed the bread on resident #23's plate. At 11:56 a.m., resident #23 ate the buttered bread independently.

An observation on 8/13/12 at 11:52 a.m. revealed Direct Care Staff G touched the table and his/her shirt then touched resident #6's bread with his/her bare hand. Staff G buttered the bread, folded the bread in half with his/her bare hands, and placed the bread in resident #6's hand. At 11:53 a.m., resident #6 ate the buttered bread independently.

An observation on 8/13/12 at 11:54 a.m. revealed Direct Care Staff G failed to wash his/her hands. Staff G pulled the chicken meat into bite-sized pieces with his/her bare hands, placed chicken on a fork, and placed the fork in resident #6's hand. Resident #6 ate the chicken on the fork independently.

During observations on 8/13/12 between 11:58 a.m. and 12:00 p.m., Dietary Staff T touched the kitchen service window countertop and resident meal cards with gloved hands. Staff T failed to put on clean gloves then served a bowl of strawberry applesauce to resident #41, #10, #39, and #34 by putting his/her contaminated gloved thumb into the side of the bowl.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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During observations on 8/13/12 between 11:58 a.m. and 12:25 p.m., Dietary Staff R touched the kitchen countertop, resident meal cards, and his/her shirt with gloved hands. Staff R failed to put on clean gloves and separated 35 of the 38 resident's chicken joined leg and thigh with his/her contaminated gloved hands.

During observations on 8/13/12 between 11:58 a.m. and 12:25 p.m., Dietary Staff S touched the countertop and resident meal cards with gloved hands. Staff S failed to put on clean gloves and used a contaminated gloved hand to place 36 of the 38 residents' sliced bread on the residents' plates.

During an interview on 8/13/12 at 12:42 p.m., Direct Care Staff N confirmed he/she contaminated the resident's food by touching bread with bare hands and Direct Care Staff G confirmed the facility expected staff to wear gloves while touching resident food.

During an interview on 8/13/12 at 12:33 p.m. Dietary Staff T confirmed he/she failed to serve the residents' applesauce in a sanitary manner when he/she touched the residents' applesauce with contaminated gloves.

During an interview on 8/13/12 at 12:34 p.m., Dietary Staff S and R confirmed they failed to serve food in a sanitary manner by touching the residents' food with contaminated gloves.

Although requested, the facility failed to provide a policy and procedure related to sanitary food service.

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	17E613	A. BUILDING _____ B. WING _____	08/20/2012

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F 371	Continued From page 15 The facility failed to prepare, distribute, and serve food under sanitary conditions for 36 of the 38 residents.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: The facility reported a census of 38 residents. Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including administering of all drugs and biologicals to meet the needs of 1 of the 38 residents (failed to give resident #12 sliding scale insulin as ordered by the physician).	F 425		

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Findings included:

- Resident #12's physician's orders included a 6/14/12 order to check the resident's blood sugar twice a day and a 7/19/12 order to give Humulin 70/30 Insulin on a sliding scale as follows:
* for blood sugar levels between 200 - 249 mg/dL (milligrams per deciliter), give 4 units
* for blood sugar levels between 250 - 299 mg/dL, give 5 units
* for blood sugar levels between 300 - 349 mg/dL, give 6 units
* for blood sugar levels between 350 - 399 mg/dL, give 7 units
* for blood sugar levels 400 mg/dL and greater, give 8 units

Resident #12's Admission 6/20/12 MDS (Minimum Data Set) Assessment reported severely impaired cognition and did not receive insulin in the observation period.

Resident #12's 6/27/12 care plan instructed staff to check the resident's blood sugar as ordered and to monitor for adverse effects of receiving Humulin 70/30 insulin.

Review of resident #12's July 2012 MAR (Medication Administration Record) lacked documentation that staff gave sliding scale Humulin 70/30 Insulin when the resident's blood sugar exceeded 200 mg/dL at the 8 p.m. check on 7/23/12, 7/24/12, 7/27/12, 7/29/12, 7/30/12, and 7/31/12.

During an observation on 8/14/12 at 1:53 p.m., resident #12 ambulated with a walker in his/her

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F 425	Continued From page 17 room with a slow and steady gait. During an interview on 8/16/12 at 3:30 p.m., Administrative Nursing Staff B confirmed resident #12's clinical record lacked evidence that staff gave sliding scale Humulin 70/30 Insulin when the resident's 8 p.m. blood sugar exceed 200 mg/dL on 7/23/12, 7/24/12, 7/27/12, 7/29/12, 7/30/12, and 7/31/12. The facility failed to provide pharmaceutical services including administeration of all drugs and biologicals to meet resident #12's needs by failing to give sliding scale insulin as ordered by the physician.	F 425		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441		

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isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 38 residents and had a whirlpool room on the east and west halls.

Based on observation, interview, and record review, the facility failed to provide a sanitary environment in order to prevent the development and transmission of disease and infection. The facility failed to have a hand sink available in the west hall whirlpool room for staff/residents to wash their hands. The facility also failed to clean a glucometer between resident use. (#29)

Findings included:

- An environmental tour of the facility on 8/15/12 at 3:15 p.m. revealed the whirlpool room on the west hall contained a whirlpool bath, shower, and toilet, and had no sink for staff or residents to use to wash their hands. A wire shelf on the west wall

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which contained personal care supplies had some pocket-sized containers of hand sanitizer. The room had no dispensers for hand sanitizer or hand sanitizer in close proximity of the toilet.

On 8/15/12 at 3:15 p.m., maintenance staff F confirmed the room had no sink for hand washing and also stated that facility staff had expressed concerns in the past that they had no place to wash their hands.

During an interview on 8/17/12 at 9:41 a.m. direct care staff G stated he/she had to wash his/her hands in the whirlpool while caring for residents in this room since the room did not have a hand washing sink. If a resident used the toilet, he/she used gloves, but had to use the whirlpool if he/she needed to wash his/her hands.

An interview on 8/17/12 at 12:09 p.m. with direct care staff H revealed he/she used hand sanitizer when assisting residents in the whirlpool room, but if his/her hands got soiled then he/she used the shower nozzle for hand washing.

On 8/17/12 at 1;26 p.m., licensed nurse I confirmed the west hall whirlpool room had no sink for staff to wash their hands and confirmed this created an unsanitary environment for staff and residents using the whirlpool room.

The facility's 5/16/12 Handwashing policy stated, "All personnel working in the long-term care facility are required to wash their hands before and after resident contact, before and after performing any procedure...and when hands become obviously soiled."

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F 441	Continued From page 20 The facility failed to provide a sanitary environment when the facility's west hall whirlpool room had no sink for hand washing in order for staff to maintain a sanitary environment and prevent the transmission of disease and infection. - An observation on 8/14/12 at 8:07 a.m. revealed Licensed Nursing Staff P failed to clean a glucometer prior to or after obtaining resident #29's blood sugar. During an interview on 8/14/12 at 10:21 a.m., Administrative Nursing Staff B reported the facility expected staff to clean the glucometers prior to and after use with an alcohol wipe. Although requested, the facility failed to provide a policy and procedure for the use and cleaning of the glucometers. The facility failed to provide a sanitary environment and to help prevent the development and transmission of disease and infection by failing to clean the glucometers between residents.	F 441		
F 464 SS=D	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced	F 464		

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by:
The facility reported a census of 38 residents with 19 sampled for review.

Based on observation, interview, and record review, the facility failed to provide adequate furnishings to accommodate the dining needs for 1 of 19 sampled residents. (#6)

Findings included:

- Resident #6's 6/5/12 Quarterly MDS (Minimum Data Set) Assessment reported severely impaired cognition and limited assistance of 1 staff for eating.

Resident #6's care plan included an entry on 12/21/11 that instructed staff to bring the resident out to the dining area in a geri-chair (a large, reclined chair that assisted residents to sit upright) at lunch time for short periods of time and assist the resident to eat.

During observations on 8/13/12 between 11:26 a.m. and 12:30 p.m., resident #6 sat in a geri-chair approximately 3 feet away from a dining room table. Direct Care G sat with his/her back to resident #6 and turned toward resident #6 occasionally to hand him/her food to eat independently.

During an observation on 8/15/12 at 7:40 a.m., resident #6 laid in a slumped position in his/her bed with the head of the bed raised to approximately 30 degrees. Direct Care Staff O placed resident #6's breakfast tray on a bedside table and positioned resident #6's bedside table over the resident and above the bed's left side rail

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(approximately 1 1/2 feet above the resident's chest). Direct Care Staff O raised the resident's head of bed to approximately 45 degrees but failed to pull resident #6 toward the head of the bed.

During observations on 8/15/12 between 7:40 a.m. and 8:51 a.m., resident #6 reached up to the breakfast tray positioned 1 1/2 feet above his/her chest and ate independently. At 8:51 a.m., resident at 10% of his/her breakfast meal. Staff failed to assist the resident to eat or attempt to reposition the resident to a closer, seated position to his/her breakfast tray.

During an interview on 8/16/12 at 10:59 a.m., Administrative Nursing Staff B confirmed the facility failed to provide adequate furnishings for resident #6's dining needs while in the dining room and while he/she ate in bed. Staff B reported that staff provided a bedside table for resident #6 in the dining area but could not fit a bedside table under the bed if staff lowered the side rail. Observations during the interview revealed Administrative Nursing Staff B placed a bedside table under resident #6's bed while the side rail remained in the lowered position.

The facility failed to provide adequate furnishings to accommodate the dining needs for resident #6 in the dining room and in his/her room.